Dental Records Release Form

Patient Name: _____ **Date of Birth:** _____

I _____**,** hereby authorize the doctor and staff of:
(Patient's Name or Legal Guardian)

Dr. Spencer Zaugg, Family & Implant Dentistry
176 South 32nd St. West, Suite #2
Billings, MT 59102
Phone: 406-655-0887
Fax: 406-969-3781
drspencerzaugg@gmail.com

to release records concerning my dental health. I understand that the specific type of information disclosed may include a detailed report of examinations, treatment provided, x-rays and other records that pertain to my dental information.

Records being requested:

( ) Current Radiographs	( ) Dental Health Status	( ) Reports
( ) Diagnostic Casts	( ) Treatment Record	( ) Charts
( ) Health History	( ) Prescription Records	( ) Photos
( ) Treatment Plan	( ) Billing Records	( ) Other: _____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED: _____

Release to: ( ) Self ( ) Dental Provider ( ) Other _____

_____
(Name of Healthcare Provider/ Myself/Other)

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Phone:** _____

Fax: _____ **Email:** _____

Delivery Options: ( ) Mail ( ) Email ( ) Fax ( ) Pick-Up

To be picked up, I authorize _____ to pick up my records. **(photo ID required)**

When transferring information to another office, we only send current x-rays, (bitewing x-rays, full mouth x-rays and Panorex) within the last 5 years and treatment dates for prophy's (cleanings), exams, scale & root planning.

Expiration: This Authorization is good for one year unless dates filled in below

From: _____ **To:** _____

Signature of Patient/ Legal Guardian:

_____ _____

Name of Patient or Legal Guardian (Print) Date

_____

Signature of Patient or Legal Guardian

_____

Relationship to Patient

By signing, I understand that the information released per this authorization, if redisclosed by the recipient, is no longer protected by Dr. Spencer Zaugg, Family & Implant Dentistry.